

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AISC 155 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03223

3250 CERTIFICATE OF DEATH

Reg. Dist. No. 258

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	QUEEN ANNE	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY QUEEN ANNE	CHESTER	(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	CHESTER	LENGTH OF STAY (in this place)	LIFE	STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print)				4. DATE OF DEATH			
5. SEX <input checked="" type="checkbox"/>	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH WIDOWED Nov. 2, 1855	9. AGE last birthday 100 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL W. JONES		14. MOTHER'S MAIDEN NAME Sarah A. Thompson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Miss ANNIE BENTLEY, CHESTER, MD.		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) Hypotension ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Ch. Enteritis, Enterocolitis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Stevensville		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from.....							
alive on..... March 8, 1956 , and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE Thos E. Fungate M.D. ADDRESS (Street, city, town, state) Stevensville DATE SIGNED 3/8/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 10 1956		NAME OF CEMETERY OR CREMATORIAL Kingsley CHURCH		LOCATION (City, town, or county) CHESTER MD.	
24. REC'D BY REGISTRAR MAR 12 1956		REGISTRAR'S SIGNATURE Mabely. B. Fungate		25. FUNERAL DIRECTOR'S SIGNATURE W. Fungate		ADDRESS Gulf Easony, Md.	
DATE							

WISCONSIN STATE FARM BUREAU FEDERATION - 1955

1955 CERTIFICATE OF DEATH

BUREAU V. S.
REGISTRY
MAR 12 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3251

CERTIFICATE OF DEATH

03224
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Annes		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE b. COUNTY Maryland Florida	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		c. LENGTH OF STAY IN lb 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wairaven Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Petersburg	
3. NAME OF DECEASED (Type or print) NANCY G. BLACKWELL		d. STREET ADDRESS	
4. DATE OF DEATH March 22		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1865
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) instructor Supervisor-Languages		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Smithfield, Va.	
13. FATHER'S NAME Richard Dunn Blackwell		14. MOTHER'S MAIDEN NAME Virginia Folk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT Mrs. Austin F. Roberts, Sudlersville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Austin Pauline Blackwell Chronic myocarditis Primal Pauline Sclerosis	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) T.S. Smith		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) W	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 • White Not white p.m. at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1954, to March 22, 1956, that I last saw the deceased alive on March 22, 1956, and that death occurred at 2 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE C. H. Metcalfe M.D.		ADDRESS (Street, city or town, state) Sudlersville, Md. DATE SIGNED Mar. 23, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 26/56	
22c. NAME OF CEMETERY OR CREMATORIUM Ivy Hill Cemetery		22d. LOCATION (City, town, or county) Smithfield, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		24a. REC'D BY REGISTRAR DATE Mar. 23	
		24b. REGISTRAR'S SIGNATURE Edgar L. Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE INSURANCE DEPARTMENT
CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3252

CERTIFICATE OF DEATH

03225
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Skinner's Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alfred	Middle H?	Last Davies
4. DATE OF DEATH	Month Mar. 13,	Day 1956	Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1867
9. AGE (In years from birthday) 88 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? (by marriage U.S.A.)	
13. FATHER'S NAME Benjamin Davies		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no 17. INFORMANT H. Morris Davies Address Norton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521.0 DUE TO <i>Cirrhosis of Liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Starvation</i> . (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 9, 1957</u> , to <u>Mar. 13, 1956</u> , that I last saw the deceased alive on <u>Mar. 13, 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>L. P. Atwell</u> ADDRESS (Street, city or town, state) <u>Still Pond Md.</u> DATE SIGNED <u>3/13/56</u>			
PHYSICIAN'S NAME (Type) L. P. Atwell, M.D.		Still Pond, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM St. John's (Longgreen)		22d. LOCATION (City, town, or county) Hyde - Balto. Co. Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE <u>3/14</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF REGISTRATION
DEPARTMENT OF HIGHER EDUCATION

BUREAU V. S.
RECEIVED
MAR 30 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03226

3253 CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH

COUNTY QUEEN ANNE'S
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN RURAL CENTREVILLE

MARYLAND
 LENGTH OF STAY
 (in this place)
30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Queen Anne's
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN RURAL CENTREVILLE

STREET
 ADDRESS

3. NAME OF
 DECEASED
 (Type or Print)

(First) Adolph Traugott (Middle) Doebler (Last)

4. DATE (Month) (Day) (Year)
 OF DEATH Mar. 4 1956

5. SEX

6. COLOR OR
 RACE Male White

10a. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if
 retired) FARMER

7. SINGLE, MARRIED,
 WIDOWED, DIVORCED,
 (Specify) Married

10b. KIND OF BUSINESS
 OR INDUSTRY CHICKEN FARM

8. DATE OF BIRTH July 6, 1893

11. BIRTHPLACE (State or foreign country) Maryland

9. AGE last birthday 62 yrs.

IF UNDER 1 YEAR
 Months 0 Days 0 Hours 0 Min. 0

12. CITIZEN OF WHAT
 COUNTRY? U.S.A.

13. FATHER'S NAME

William Francis Doebler

14. MOTHER'S MAIDEN NAME

Josephine Jacobs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) Yes (If Yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Mrs. Frank Street Doebler, Centreville, Md.

INTERVAL BETWEEN
 ONSET AND DEATH

3 hour

18. MEDICAL CERTIFICATION

451X IMMEDIATE CAUSE (A) Decaying Arterio Barter

ANTECEDENT CAUSE(S) DUE TO (B) Arterio sclerosis Aorta

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

STATING UNDERLYING CAUSE LAST. DUE TO (C)

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE
 DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT WAS UNDERLYING
 OR CONTRIBUTING CAUSE OF DEATH
 (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
 While Not while
 at work at work

21f. HOW DID INJURY OCCUR?

M. L.

22. I hereby certify that I attended the deceased from March 4, 1956, to March 4, 1956, that I last saw the deceased

alive on March 4, 1956, and that death occurred at 2 PM, from the causes and on the date stated above.

SIGNATURE John L. Lester

ADDRESS (Street, city, town, state)

DATE SIGNED 3-6-56

23. BURIAL, CREMATION,
 REMOVAL (SPECIFY)

DATE THEREOF Mar. 6, 1956

NAME OF CEMETERY OR CREMATORIAL

Chesapeake Cemetery

LOCATION (City, town, or county)

Centreville, Maryland

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE Ebie Armstrong

BUTTER BROS.

JONES & BOSTON, JR.

Centreville, Maryland

ADDRESS

DATE 3-6-56

25. FUNERAL DIRECTOR'S SIGNATURE

BUTTER BROS.

JONES & BOSTON, JR.

Centreville, Maryland

ADDRESS

RECEIVED STATE PLANNING OFFICE - BOSTON

CERTIFICATE OF DATA

DATA

DATA

DATA

BUREAU V. S.

MAR 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103227

3254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 251

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Susan Ame</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. LENGTH OF STAY IN lb <u>all her life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hattie Celia Frazier</u>		First <u>Hattie</u>	Middle <u>Celia</u>
4. DATE OF DEATH <u>March 27 1956</u>	Month <u>March</u>	Day <u>27</u>	Year <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April</u>
9. AGE (In years last birthday) <u>66 yrs.</u>	10. IF UNDER 1 YEAR Months <u></u>	11. IF UNDER 24 HRS. Days <u></u>	12. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Don't know</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mary Ellen Smith</u> Address <u>Granddaughter Centreville Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
DUE TO (b) <u>She has had Bronchial asthma</u>			
DUE TO (c) <u>for number of years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W.S. Henry Fisher</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/27-56</u>
EXAMINER'S NAME (Type) <u></u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 30</u>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Chesterfield</u>	22d. LOCATION (City, town, or county) <u>Centreville Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>3/27</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar H. Lane</u>

BUREAU V. S.

APR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04394

3255

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <i>Ind.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GEORGE WASHINGTON HORNEY</i>		First <i>Ind.</i>	Middle <i>Ind.</i>
4. SEX <i>Male</i>		5. COLOR OR RACE <i>W.H.</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH <i>April 12-1870</i>		8. DATE OF DEATH Month <i>Mar.</i> Day <i>29</i> Year <i>1956</i>	
9. AGE (In years last birthday) <i>85 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>	
11. BIRTHPLACE (State or Foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm. Horney</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tell, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>Amos Horney</i>	
17. INFORMANT <i>Amos Horney</i>		Address <i>Chester Ind.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>myocardial insufficiency</i> DUE TO (c) <i>Arteriosclerosis, general + cerebral</i>		INTERVAL BETWEEN ONSET AND DEATH <i>March 29, 56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ind.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 20</i> , 1956, to <i>March 29</i> , 1956, that I last saw the deceased alive on <i>March 28</i> , 1956, and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Stevensville</i> DATE SIGNED <i>Ind. 3/29/56</i>	
ACTUAL SIGNATURE <i>Theodor Sattelmair</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Theodor SATTELMAIER</i>			
22a. BURIAL/CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar 31</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Stevensville</i>		22d. LOCATION (City, town, or county) <i>Stevensville Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>		24a. ADDRESS <i>Church Hill Ind.</i>	
24b. REG'D BY REGISTRAR <i>Elizabeth Koester</i>		DATE <i>April 6-56</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03228

Reg. Dist. No. 251

3256

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Centreville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Shirley	Middle K.	Last Hynson
4. DATE OF DEATH	Month March	Day 13	Year 1956
5. SEX Fem.	6. COLOR OR RACE Coh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1955
9. AGE (in years last birthday) yrs 10		10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hynson		14. MOTHER'S MAIDEN NAME Bertha May Denby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Hynson--Centreville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 day	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12, 1956 , to March 13, 1956 , that I last saw the deceased alive on March 12, 1956 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE C.R. Layton PHYSICIAN'S NAME (Type) C.R. Layton		ADDRESS (Street, city or town, state) Centreville Md DATE SIGNED 3-13-56	
22a. BURIAL, CREMATION, REMOVAL SPECIAL Burial		22b. DATE THEREOF Mar. 14	
22c. NAME OF CEMETERY OR CREMATORIAL Roesville		22d. LOCATION (City, town, or county) Near Centreville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar S. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DATE 3-13		24b. REGISTRAR'S SIGNATURE Edgar S. Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SA DIVINA



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103229

3257

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>ND.</i>		b. COUNTY <i>KENT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pondtown</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GOLTS</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>HANNAH</i>	Middle <i>E.</i>	Last <i>JOHNSON</i>	4. DATE OF DEATH Month <i>MARCH</i>	Month <i>6</i>	Day <i>19</i>	Year <i>56</i>
5. SEX <i>F.</i>	6. COLOR OR RACE <i>COLORED</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE-25-1883</i>	9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOSEPH MARTIN</i>		14. MOTHER'S MAIDEN NAME <i>HANNAH LEE</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Viola Comegys - Millington MD.</i>		Address <i>Millington MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 weeks</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertension</i>						2.	
DUE TO <i>Hardening of the arteries -</i>						2.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 31, 1955</i> , to <i>March 6, 1956</i> , that I last saw the deceased alive on <i>March 5, 1956</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ezra Koralewski</i>		ADDRESS (Street, city or town, state) <i>Millington, Md.</i>		DATE SIGNED <i>3-8-56</i>			
PHYSICIAN'S NAME (Type) <i>EZRA KORALEWSKI</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/10/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>NEW BETHEL C.I.M.</i>		22d. LOCATION (City, town, or county) (State) <i>GOLTS, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward L. Lane, Millington, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>3-9</i>		24b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>	

RECEIVED V. S.

MAR 9 1 1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03250

3258

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <i>Dover Pine</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>No.</i>		b. COUNTY <i>KENT</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Millington</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILLINGTON</i>		d. STREET ADDRESS <i>14x-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HARRY</i>		First	Middle	Last	4. DATE OF DEATH <i>MERRILL</i>	Month	Day	Year	
5. SEX <i>M</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2 day 1888</i>	9. AGE (In years last birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CYSTERMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SHUCKER</i>		11. BIRTHPLACE (State or foreign country) <i>No.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>219-03 385-1-A</i>		17. INFORMANT <i>MARY POTTS.</i>		Address <i>Millington, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>					
(b) DUE TO <i>Un. Cardio Renal Disease</i>				2 years					
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Aprr 12</i> , 1958, to <i>Mar 6</i> , 1958, that I last saw the deceased alive on <i>Mar 2</i> , 1958, and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. H. Hamilton</i>		M.D.		ADDRESS (Street, city or town, state) <i>Millington, Md.</i>		DATE SIGNED <i>3/8/58</i>			
PHYSICIAN'S NAME (Type) <i>H. H. HAMILTON</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>MARCH 10, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>NILEYS NECK, CEM.</i>		22d. LOCATION (City, town, or county) <i>Rural Millington</i>		(State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Hollens</i>		ADDRESS <i>Millington, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>39</i>		24b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in the funeral director's office, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 1 1968

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3259 CERTIFICATE OF DEATH

03231
251

Reg. Dist. No.

Item 4, Film #194 3-22-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Queen Anne Maryland Barclay (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)		(First) Annie (Middle) Legg (Last) Phillips	4. DATE (Month) March (Day) 6, (Year) 1956
5. SEX Fem.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 10-1861
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Thomas Legg		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Rambert Phillips--Barclay, Md.
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Congestive heart failure			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) Arteriosclerosis			
STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fractured skull			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) Mar. (Day) 9 (Year) 1956 (Hour) M.		21e. WHERE DID INJURY OCCUR? (City or town) Sudlersville (County) Carroll Co. (State) Md.	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 9, 1956 , to Mar. 10, 1956 , that I last saw the deceased alive on Mar. 9, 1956 , and that death occurred at 5 A.M. from the causes and on the date stated above SIGNATURE <i>Edgar L. Lane</i> DATE SIGNED Mar. 10, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 9	NAME OF CEMETERY OR CREMATORIAL Sudlersville M.D.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>	25. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill, Md.
DATE 3-8			

1862

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03232

3260

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH

a. COUNTY

Queen Anne

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL MILLINGTON

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

JP

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

b. COUNTY

MD

QUEEN ANNE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL MILLINGTON

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

William

First

Middle

Last

4. DATE OF DEATH

Month

Day Year

March 22 1956

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

OCT. 10, 1880

9. AGE (In years
last birthday)
yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMING + POULTRY

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

TORONTO, CANADA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE RATCLIFF

14. MOTHER'S MAIDEN NAME

JENNIE THORNDIKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

217-36-1202 MRS. CORA M. RATCLIFF, MILLINGTON, MD

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

1/2 hours

4602

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

Necrosis of the legs -

for years.

(c)

Chronic Phlebothrombosis of legs -

for years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

a. m.

19

p. m.

20d. INJURY OCCURRED

While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from March 21, 1956, to March 22, 1956, that I last saw the deceased alive on March 21, 1956, and that death occurred at 6:50 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL

TESTIMONY

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

3/24/56

22c. NAME OF CEMETERY OR CREMATORIUM

CRUMPTON CEM

CRUMPTON

22d. LOCATION (City, town, or county)

MD.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Edgar L. Lane

ADDRESS

Edgar L. Lane, Millington, Md.

24a. REC'D BY REGISTRAR

DATE

3/23

24b. REGISTRAR'S SIGNATURE

Edgar L. Lane



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3261 CERTIFICATE OF DEATH

04399

Reg. Dist. No. 253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>JAMES</i>		First <i>H.</i> Middle <i>Smith</i> Last	4. DATE OF DEATH Month <i>Mar.</i> Day <i>29</i> Year <i>1956</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>COL.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 20 - about 82 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Ind.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Anna May Smith = Cambridge, Ind.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>March 27, 56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Incarcerated left inguinal hernia (operated on March 10, 1956,</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.) <i>at Memorial Hospital</i> <i>Ranson, Md.</i>	
20c. TIME OF INJURY Hour <i>a.m.</i> <i>p.m.</i>	Month <i>Mar.</i> Day <i>29</i> Year <i>1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 27, 1956</i> , to <i>March 29, 1956</i> , that I last saw the deceased alive on <i>March 29, 1956</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodor Sattelmaier</i>	M.D.	ADDRESS (Street, city or town, state) <i>Stevensville</i> DATE SIGNED <i>March 30, 1956</i>	
PHYSICIAN'S NAME (Type) <i>Theodor SATTELMAIER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Mar. 31</i>	22b. DATE THEREOF <i>Mar. 31</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chester Col.</i>	22d. LOCATION (City, town, or county) (State) <i>Chester Ind.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>		ADDRESS <i>Church Hill Ind.</i>	24a. REC'D BY REGISTRAR DATE <i>April 6-56</i>
			24b. REGISTRAR'S SIGNATURE <i>Elizabeth Hopter</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3262

CERTIFICATE OF DEATH

Reg. Dist. No.

11323
LSP

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Ind.</i>		b. COUNTY <i>Green Anne</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sudlersville</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>		d. STREET ADDRESS <i>;</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WALRAVEN NURSING HOME</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>ELIZABETH</i>	Middle <i>TIPTON</i>	Last <i>;</i>	DATE OF DEATH <i>Mar. 29 1956</i>	Month <i>Mar.</i>	Day <i>29</i>	Year <i>1956</i>	
5. SEX <i>Fem.</i>		6. COLOR OR RACE <i>W.h.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>about 82 yrs</i>	9. AGE (In years last birthday) <i>about 82 yrs</i>	10. IF UNDER 1 YEAR Months <i>;</i>	11. IF UNDER 24 HRS. Days <i>;</i>	12. IF UNDER 24 HRS. Hours <i>;</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>;</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Henry Tibbs</i>		14. MOTHER'S MAIDEN NAME <i>Dorothea Reske</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>;</i>		17. INFORMANT <i>Mrs. Ken Harris - Chester Ind.</i>		Address <i>;</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Dilatation</i>						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO <i>;</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>;</i>		(b) <i>Chronic Myocarditis</i>							
DUE TO <i>;</i>		(c) <i>General Cardiac Sclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sensit</i>									
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>;</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>;</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <i>4/19/56</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>;</i>		20f. (City or town) <i>;</i>		(County) <i>;</i>	(State) <i>;</i>
21. I certify that I attended the deceased from <i>May 20, 1956</i> , to <i>July 29, 1956</i> , that I last saw the deceased alive on <i>July 29, 1956</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>;</i>		DATE SIGNED <i>3/31/56</i>	
ACTUAL SIGNATURE <i>C. W. Tibbs</i>		M.D. <i>;</i>							
PHYSICIAN'S NAME (Type) <i>;</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>;</i>		22b. DATE THEREOF <i>April 2</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>BONDON PARK</i>		22d. LOCATION (City, town, or county) <i>Baltimore Ind.</i>		(State) <i>;</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elgarth Lane Church Hill Md.</i>		ADDRESS <i>;</i>		24a. REC'D BY REGISTRAR DATE <i>3/31</i>		24b. REGISTRAR'S SIGNATURE <i>Elgarth Lane</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate usually should be detached for use in a burial transit permit.

VS AISC-L55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3253 CERTIFICATE OF DEATH

03234

Reg. Dist. No. 1572

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEDENT	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN	COUNTY Maryland Centreville (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)	(First) SALLIE L	(Middle)	(Last) VOSHELL
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH July 10-1876
9. AGE last birthday 79 yrs.	10. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Hemming	11. BIRTHPLACE (State or foreign country) Centreville Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.	13. FATHER'S NAME Robert F. Vane	14. MOTHER'S MAIDEN NAME Sara Jane Harwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)	16. SOCIAL SECURITY NO. No	17. INFORMANT & ADDRESS Mrs. V. Duper Centreville Md	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4. IMMEDIATE CAUSE (A) Acute Labor Pneumonia			
5. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While M. at work		21f. HOW DID INJURY OCCUR?	
Not while at work		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from 3/29/56, 1956, to 5/30/56, 1956, that I last saw the deceased alive on 3/30, 1956, and that death occurred at 11 P.M., from the causes and on the date stated above. SIGNATURE W.L. Fisher			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 2-56	NAME OF CEMETERY OR CREMATORIUM Chesterfield
24. REC'D BY REGISTRAR DATE 4-2-56		REGISTRAR'S SIGNATURE Evelyn W. Fisher	25. FUNERAL DIRECTOR'S SIGNATURE Howard Berlin
		ADDRESS Centreville Maryland	

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INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3264

CERTIFICATE OF DEATH

03235
254

Reg. Dist. No. 254

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	QUEEN ANNES Accomacian	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	00		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) ROBERT (Middle) JOSEPH (Last) WEAVER		Month (Day) (Year) March 21 - 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec-28-1879
9. AGE last birthday 76 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Hospital Barber	11. BIRTHPLACE (State or foreign country) Queen Anne's Co Md
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Charles Joseph Weaver	14. MOTHER'S MAIDEN NAME Mary Etta Council	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 219-05-6555	17. INFORMANT & ADDRESS Mrs John Bayles Accomacian Md	INTERVAL BETWEEN ONSET AND DEATH 10 days
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary artery sclerosis (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/20/1956 to 3/21/1956, that I last saw the deceased alive on 3/21/1956, and that death occurred at 10:30 A.M. from the causes and on the date stated above. SIGNATURE W. Henry Fisher			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF March 24-56	NAME OF CEMETERY OR CREMATORIUM Chesterfield	LOCATION (City, town, or county) Centserville Maryland (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE Helen M. Aldridge	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Rector	
DATE 3/23/56		DATE SIGNED 3/23/56	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3265

CERTIFICATE OF DEATH

03236
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queen Anne R.F.D.		c. LENGTH OF STAY IN 1b 72 Yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Robert Barclay Wessel		First	Middle			
4. DATE OF DEATH Month 3	Day 12	Year 1956	Month			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1883	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William H. Wessel		14. MOTHER'S MAIDEN NAME Liza Ann Travis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-0628		17. INFORMANT Bertha Wessel Queen Anne R.F.D.		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH sudden	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ridgely	20f. (City or town) Ridgely	(County) Maryland	(State) MD
21. I certify that I attended the deceased from Mar. 12 , 19 56 , to Mar. 12 , 19 56 that I last saw the deceased alive on 12 , and that death occurred at 1 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles H. Stonesifer M.D.		ADDRESS (Street, city or town, state) Greensboro, Maryland			DATE SIGNED 3/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/56	22c. NAME OF CEMETERY OR CREMATORIAL Ridgely	22d. LOCATION (City, town, or county) Ridgely, Maryland	(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bourlais		ADDRESS Greensboro Md.	24a. REC'D BY REGISTRAR DATE 3-14	24b. REGISTRAR'S SIGNATURE Edgar L. Lane		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

Mar 30 1956

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